**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA, TEXAS 77504

**Carrier's Austin Representative Box**
#05

**MFDR Date Received**

**Respondent Name**
TRAVELERS INDEMNITY CO OF AMERICA

**MFDR Tracking Number**

M4-03-3672-02 FEBRUARY 18, 2003

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary Dated March 27, 2003:** "Please find enclosed the request for Medical Dispute Resolution from Vista Medical Center Hospital. The Carrier denied payment without providing a payment exception code as the Carrier did not provide an EOB, but only a check-stub as evidence of 'final action.'…the Carrier did not complete an on-site audit. TWCC rule 134.401 provides the rules regarding reimbursement for Acute Care In-patient Hospital Fee services. Specifically, reimbursement consists of 75% of remaining charges for the entire admission, after a Carrier audits a bill…The prior amounts paid by the carrier were $89,142.73…"

**Requestor's Supplemental Position Summary Dated April 29, 2008:** "Please accept and consider this Supplement to Vista Medical Center Hospital's Request for Medical Dispute Resolution. Vista offers this supplement as relevant information to this fee dispute since its remand from the …('SOAH')…"

**Amount in Dispute (taken from the table of disputed services):** $49,575.24

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary Dated April 8, 2008:** "…The Provider's bill involves the charges for the hospitalization of the Claimant for surgery. The Provider billed the Carrier $187,324.41 for the total cost of the 7-day hospitalization. The Carrier reimbursed the Provider a total of $89,142.73 based on the surgical per diem rate plus implantables at cost plus ten percent. The Claimant was hospitalized for three level fusion with instrumentation and laminectomy. There were no complications, and the 7-day admission was neither unusually extensive nor expensive for the condition and treatment rendered. ..The Provider has not shown that it rendered unusually costly or extensive services. ..The Provider has not documented that the procedure was unusually extensive or unusually expensive. Therefore, the Provider has not shown itself to be entitled to additional reimbursement…"

**Response Submitted by:** Travelers

## *SUMMARY OF FINDINGS*

| Disputed Dates | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 13 2002 | Outpatient Hospital Services | $49,575.24 | $0.00 |
| March 14 through 21, 2002 | Inpatient Hospital Services | | |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.304, 25 *Texas Register* 2115, amended effective July 15, 2000 sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated May 3, 2002 for date of service March 13, 2002

- Payt – (M) – procedure/service was reimbursed in accordance with the fair and reasonable allowance.
- Rej – the billed procedure code is not listed in the fee schedule
- Prof (F) – reimbursement for hospital physician services must be billed using the HCFA-1500

Invoice Explanation of Review Summary (undated)

- M – Hospital bill reviewed by prompt associates. The payment is based on ucr for geographic area. Explanation is under separate cover. (Note: no further explanation was provided by the carrier.)

Dispute M4-03-3672 was originally decided on September 27, 2004 and subsequently appealed to a contested case hearing at the State Office of Administrative Hearings (SOAH) under case number 453-05-1633.M4. This dispute was then remanded to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) pursuant to an August 17 2007 SOAH order of remand due to incorrect carrier notification. As a result of the remand order, the dispute was re-docketed at medical fee dispute resolution and is hereby reviewed.

**Issues**

1. Does this dispute include inpatient and outpatient hospital services?
2. Is the requestor entitled to additional reimbursement for the outpatient services rendered on March 13, 2002?
3. Did the audited charges exceed $40,000.00?
4. Did the admission in dispute involve unusually extensive services?
5. Did the admission in dispute involve unusually costly services?
6. Is the requestor entitled to additional reimbursement for inpatient hospitalization rendered from April 9, 2002 through April 13, 2002?

**Findings**

This dispute relates to outpatient services and inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR

submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the request does not include a copy of the medical bill(s) as submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(A).

   Review of the submitted explanation of benefits finds that the requestor billed $2,938.73 for date of service March 13, 2002 on an outpatient hospital bill; and $186,284.87 for dates of service March 14 through March 21, 2002 on an inpatient hospital bill. 28 Texas Administrative Code §134.401(b)(1)(B) states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital."

   The Division finds that the services rendered on March 13, 2002 were outpatient hospital services and the services rendered on March 14 through March 21, 2002 were inpatient hospital services.

2. Date of service March 13, 2002 is subject to the provisions of 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) [currently Texas Labor Code §413.011(d)], until such period that specific fee guidelines are established by the commission.

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for the outpatient services would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

3. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the Invoice Explanation of Review Summary (undated) issued by the carrier for dates of service March 14 through 21, 2002 finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the Division concludes that the total audited charges exceed $40,000.

4. The requestor in its original position statement asserts that "…TWCC Rule 134.401 provides the rules regarding reimbursement for Acute Care In-patient Hospital Fee services. Specifically, reimbursement consists of 75% of remaining charges for the entire admission, after a Carrier audits a bill…" As noted above, the Third Court of Appeals' November 13, 2008 opinion rendered judgment to the contrary. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

5. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds $40,000.00, the stop loss method of payment should apply. The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to demonstrate that the services in dispute are unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6) of this section.

6. For the reasons stated above, dates of service March 14 through March 21 2002 are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was seven days. The surgical per diem rate of $1,118 multiplied by the length of stay of seven days results in an allowable amount of $7,826.00.
- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."

| Rev Code | Itemized Statement Description | Cost Invoice Description | UNITS / Cost Per Unit | Total Cost | Cost + 10% |
|---|---|---|---|---|---|
| 278 | Implant assembly | Silhouette, sleeve with set screw, assy | 2 @ $225.00 | $450.00 | $495.00 |
| | TC/assorted sizes | connector transverse, 44mmx57mm, internal, silhouette | 2 @ $165.00 | $330.00 | $363.00 |
| | Implant spinal fus/stim(s) | Not supported | 1 | NA | NA |
| | Interbody bak cage | Bak/l, assy, 13x24mm, package, implant, sterile | 4 @ $2565.00 | $10,260.00 | $11,286.00 |
| | Cancellous chip 30cc | Cancellous chips 30cc | 2 @ $495.00 | $990.00 | $1089.00 |
| 278 | Endcap 13mm | Assy, package, implant, 13mm, sterile bak/L, endcap | 4 @ $150.00 | $600.00 | $660.00 |
| | Osteofill 10cc (bonepaste) | Osteofil paste 10cc | 3 @ $1150.00 | $3450.00 | $3795.00 |
| | Locking nut | Silhouette locking nut | 6 @ $115.00 | $690.00 | $759.00 |
| | Transconnector nut | Silhouette nut, locking, transverse connector | 4 @ $55.00 | $220.00 | $242.00 |
| | Transconnector insert | Silhouette transverse connector insert | 4 @ $85.00 | $340.00 | $374.00 |
| | Rod 5.5 | Silhouette rod, 5.5mm x 10cm | 2 @ $180.00 | $360.00 | $396.00 |
| | Rod template | Asy, rod template, 15cm, nonsterile, packaged | 1 @ $105.00 | $105.00 | $115.50 |
| | Screws 7 x 45 mm;<br>7 x 50 mm; and<br>7 x 55 mm | Invoice # 159167 supports **7.5** x 45 mm screws; **7.5** x 50 mm screws; and **7.5** x 55 mm screws. | 4<br>1<br>1 | NA | NA |
| | | | TOTAL ALLOWABLE $19,574.50 | | |

- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $315.67 for revenue code 382-Whole Blood and $299.00 for revenue code 391-Blood Administration. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue codes 382 and 391 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $488.75/unit for Epidural: Fent & Bupiv.1; $289.00/unit for Dilaudid PCA 100ML; and $828.00/unit for Albumin 25gm. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is $27,400.50. The respondent issued payment in the amount of $89,142.73. Based upon the documentation submitted no additional reimbursement can be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor for the outpatient services rendered on March 13, 2002. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, no additional reimbursement can be recommended.

In addition, the submitted documentation does not support the reimbursement amount sought by the requestor for the inpatient admission of March 14 through 21, 2002. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | December 2012 |
| Signature | Medical Fee Dispute Resolution | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.